

<b>Case Number:</b>	CM14-0211756		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	07/19/2012
<b>Decision Date:</b>	04/10/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Neurological Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 50-year-old male on 07/19/2012 reported working as a carpenter applying concrete to vertical walls when he experienced sudden onset of severe pain in his left shoulder with an accompanying tearing sound. His pain worsened with time and then he ruptured his right biceps with radial collateral and lateral ulnar ligament tears while moving a mattress. He had an AC joint resection in 2001, a superior labral anterior-posterior tear repair (SLAP) in 2003 with followup surgery in 2009. On 10/12/2012, he had a right biceps rupture and ligament repair. A left arthroscopic labral repair surgery was done on 02/12/2013. A MRI of the left shoulder on 07/28/2014 showed evidence of previous rotator cuff repair with diffuse supraspinatus tendinopathy, a 7x12mm full thickness midsupraspinatus cuff tear and diffuse distal bursal surface degenerative fraying or superficial tears with prominent subdeltoid fluid. Marked glenohumeral degenerative arthritis with subchondral cystic changes in the inferior glenoid were seen along with posterior labral degenerative changes and postoperative changes along the anterosuperior labrum. His diagnoses include left shoulder pain, and left shoulder post-traumatic arthritis with rotator cuff tear arthropathy. Treatments have included oral medications, topical pain medication, and an electrodiagnostic study. The progress report dated 11/07/2014 indicates that the injured worker complained of bilateral upper extremity pain and left shoulder pain. The pain level had increased since the last visit. He rated his pain 7 out of 10 with medications and 10 out of 10 without medications. His activity level has decreased. The treating physician requested a left shoulder hemiarthroplasty and associated treatments. Documentation did not show details of physical therapy, injections or medication changes. The progress report dated

11/07/2014 indicates that the injured worker complained of bilateral upper extremity pain and left shoulder pain. The pain level had increased since the last visit. He rated his pain 7 out of 10 with medications and 10 out of 10 without medications. His activity level has decreased. The treating physician requested a left shoulder hemiarthroplasty and associated treatments. On 12/03/2014, Utilization Review (UR) denied the request for left shoulder hemiarthroplasty, inpatient stay for 2 days, Norco 10/325mg #60, Percocet 10/325mg #60, post-operative cold therapy unit times 14 days, post-operative physical therapy 2 times a week for 6 weeks, pre-operative complete blood count (CBC), comprehensive metabolic panel (CMP), international normalized ratio (INR), partial thromboplastin time (PTT), pre-operative EKG, and pre-operative electromyography/nerve conduction study (EMG/NCS). The UR physician noted that there was no documentation of shoulder degeneration or severe joint space stenosis; since the surgery was denied, the request for pre-operative diagnostic testing was non-certified; since the surgery was denied, the request for the post-operative durable medical equipment, physical therapy, and pain medication was non-certified; and since the surgery was denied, the request for an inpatient stay was non-certified. The MTUS Chronic Pain Guidelines, ACOEM Guidelines and Non-MTUS Official Disability Guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **Left shoulder hemiarthroplasty: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Arthroplasty.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter-shoulder arthroplasty.

**Decision rationale:** The ODG guidelines indicate that according to the literature a hemiarthroplasty is more commonly performed in those patients with trauma. The list of indications includes failure of conservative therapies for at least six months. Documentation does not include evidence of such a failure in this patient. The guidelines also note that arthroplasty is not recommended in cases of irreparable rotatorcuff tear. This patient does not have evidence of severe joint space stenosis which is another criteria for surgery. Thus the requested treatment: Left shoulder hemiarthroplasty is not medically necessary and appropriate.

#### **Hospital inpatient stay for two days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Arthroplasty and Hospital Length of Stay (LOS).

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-operative EMG/NCS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-operative EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-operative labs (CBC, CMP, INT, and PTT):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative cold therapy unit rental for 14 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative physical therapy twice a week for six weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Percocet 10/325mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Norco 10/325mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.